

23 The role of the Health and Disability Commissioner and the Code of Rights

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The Health and Disability Commissioner (the Commissioner) is an independent ombudsman set up to

- promote and protect the rights of consumers who use health and disability services; and
- facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringement of those rights.

The Commissioner enforces a Code of Health and Disability Services Consumers' Rights (the Code). The Code confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

The Health and Disability Commissioner Act 1994 was amended in 2004 to address a number of problems with the complaints system. The amendments, which came into effect in September 2004, streamline complaints mechanisms, give the Commissioner greater flexibility to resolve complaints, and increase the interface with other agencies.

The Code of Rights

The Code became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act 1994 (the HDC Act).

Application of the Code is very wide and includes public and private services, paid and unpaid services, hospitals, and individuals. The Code covers all

registered health professionals, such as doctors, nurses, and dentists, and in addition brings a level of accountability to other providers such as naturopaths, caregivers, and even people who care for family members with a disability. The Commissioner can consider systems issues as well as individual actions.

The rights set out in the Code are not comprehensive. For example, the right to patient confidentiality is affirmed in separate privacy legislation (see chapter 13 on medical records), and the Code does not extend to funding decisions or confer entitlement to any particular service. The Code does not override duties or obligations established in other legislation.

Nor are the rights absolute. It is a defence for a provider to show that he or she took “reasonable actions in the circumstances to give effect to the rights, and comply with the duties” in the Code. “The circumstances” are defined to include the consumer’s clinical circumstances, the provider’s resource constraints, and any other relevant circumstances.

In summary, there are ten rights.

1. Consumers should always be treated with respect.
2. No one should discriminate against consumers, pressure them into anything, or take advantage of them.
3. Services should help consumers to live dignified, independent lives.
4. Consumers should be treated with reasonable care and skill and receive well coordinated services.
5. Service providers should listen to consumers and give them information in a way they can understand and that makes them comfortable to ask questions if they don’t understand. This may require the services of an interpreter.
6. Consumers should have any treatment explained to them, including benefits, risks, alternatives, and costs, and have any questions answered honestly.
7. Consumers can make their own decisions about treatment, and are free to change their mind.
8. Consumers can have a support person with them at most times.
9. All these rights apply if consumers are asked to take part in research or teaching.
10. Consumers have a right to make a complaint and have it taken seriously.

All doctors should be familiar with the Code,¹ and should make it available to patients. A full copy can be obtained from the Commissioner’s website (www.hdc.org.nz) or by phoning 0800 11 22 33.

Complaints resolution

Any person (the consumer, a family member, or even another provider) may complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code. Complaints made to an advocate that remain unresolved after advocacy assistance must be referred to the Commissioner, and the Medical Council must refer all patient care complaints about doctors to the Commissioner. The Commissioner is responsible for ensuring that each complaint about health care and disability services providers is dealt with appropriately.²

On receipt of a complaint, the Commissioner is required to make a preliminary assessment of the complaint to decide what course of action, if any, is appropriate. The HDC Act supports resolution of complaints at the lowest appropriate level.

No action

The Commissioner may, at his or her discretion, decide to take no action on a complaint if he or she considers that any action is unnecessary or inappropriate. This may occur where, for example

- the length of time that has elapsed between the incident and the making of the complaint is such that an investigation is no longer practicable or desirable
- the subject matter of the complaint is trivial
- the complaint is frivolous or vexatious
- the consumer does not want action to be taken
- there is an adequate remedy which it would be reasonable for the complainant to exercise, or
- the matter has been fully investigated and reviewed, and any recommendations of the review have been implemented, and an HDC investigation is unlikely to shed further light on the matter.

Case study

Mrs A, an insulin dependent diabetic who also had low grade non Hodgkin's lymphoma, arrived at a public hospital Emergency Department by ambulance at 10.10am with a history of right leg pain and a fall at her home that morning. On arrival, Mrs A was immediately triaged and allocated a triage code 3, indicating that she needed to be seen by a doctor within 30 minutes. Mrs A was not reviewed by a doctor until 4pm that afternoon. According to the records, on examination Mrs A had hypotension, confusion, renal failure, and sepsis secondary to cellulitis/gangrene of her right leg. She was admitted to the Intensive Care Unit and managed for multi-organ failure until a decision was made to withdraw treatment nine days later.

Following Mrs A's death, the District Health Board commissioned an external review to determine whether the care and treatment provided to her in the Emergency Department met an acceptable standard. The review was headed by a senior nursing consultant and an emergency medicine consultant from separate District Health Boards. The review concluded that the care and treatment provided to Mrs A did not meet an acceptable standard, and made a number of recommendations designed to improve the systems and processes in the Emergency Department.

Ms B, Mrs A's daughter, was involved in the external review. Following its completion she contacted the Commissioner, concerned whether the recommended changes had been implemented.

On receipt of Ms B's enquiry, the Commissioner wrote to the District Health Board requesting specific advice on the actions it had taken to give effect to the recommendations. The District Health Board responded promptly and in detail, providing an "Action Plan", which clearly set out the recommendations and changes needed, how the changes would take place, who was responsible for them, and the dates for completion. The Action Plan showed that seven months after completion of the review, a number of the recommended changes had been implemented and the majority were in process.

The Commissioner wrote to Ms B, providing her with a copy of the Action Plan and explaining some of the specific initiatives being developed in the Emergency Department.

These included an electronic patient management system and structural changes to the layout of the department. Ms B advised the Commissioner that she was very happy with the outcome and hoped that the situation that had contributed to her mother's death would be unlikely to occur again. The Commissioner's file was closed without need for any further action.

Due to the quality of the external review, and the willingness of the District Health Board to implement the recommendations, a potentially serious complaint was resolved without formal investigation.

Provider resolution

Often the quickest and most satisfactory way of dealing with grievances is for the consumer to deal directly with the provider. The Code requires that providers have a complaints procedure, and sets out minimum requirements for keeping consumers informed about the progress of their complaint. Consumers are entitled to the assistance of a support person or an independent advocate when making a complaint.

The Commissioner may refer a complaint to the provider for resolution if the complaint does not raise public safety issues and can be appropriately resolved by the provider. In some cases, the provider may not have been aware of the complaint and may be well motivated to resolve the complaint directly with the consumer. All referrals to a provider are accompanied by reporting requirements back to the Commissioner. This enables the Commissioner to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues are addressed, and independent oversight is maintained. The Commissioner may take further action if not satisfied with the reported outcome.

Case study

The Commissioner received a complaint relating to Ms C's care over a year or more by providers from many disciplines, all within one District Health Board. The patient complained of her "year of hell". She acknowledged that taken in isolation the matters she complained of could appear trivial, but in total they had had a serious effect on her health. After discussion with the District Health Board's chief executive officer, and with Ms C's agreement, the District Health Board took over the complaint, looked into it, met with the patient, and achieved a speedy resolution which satisfied Ms C. She reported the positive outcome to the Commissioner before the District Health Board had reported back. This complaint would have been difficult and lengthy to investigate, and the outcome would probably not have been so positive.

Advocacy

Free independent advocacy services are available throughout New Zealand. Advocates promote awareness of the Code and HDC Act, providing free education sessions to consumers and providers. They assist consumers to resolve complaints at an early stage and encourage self advocacy as well as providing more support as needed.

Advocates do not make decisions on whether there has been a breach of the Code. Rather, their role is to give consumers information about their rights, and to support them to make decisions and take action to attempt to resolve the

complaint. Most complaints that advocates handle are received directly rather than via the Commissioner, but in some cases the Commissioner may decide that a complaint made to his office should be referred to an advocate to enable the parties to resolve the matter. The majority of complaints referred to advocacy are successfully resolved, often by face to face meetings with providers. Advocates must refer any unresolved complaints to the Commissioner and may also report on any matter concerning the rights of consumers that they consider should be brought to the Commissioner's attention.

The nationwide health and disability service is provided by an independent national advocacy trust through a contractual arrangement with the Director of Advocacy. The advocacy service can be contacted by freephone on 0800 555 050, free fax on 0800 2787 7678 or at advocacy@hdc.org.nz.

Case study

Mrs D was provided with verbal and written information about advocacy and the Code after relaying the following information: on a number of occasions she and her doctor had discussed the probability that she would need to start an antihypertensive. At a consultation her blood pressure was noted, yet again, to be high, and the doctor advised that it was now time to start the treatment. They again discussed her reluctance to commence the treatment, but she agreed to do so. Mrs D was told the name of the medication being prescribed and she asked about possible side effects. The doctor told her she would know if she experienced any and she should return if she did. Mrs D then requested the same information from the dispensing pharmacist, who advised that it is not the pharmacy's normal practice to provide such information about the medication.

Mrs D was very disturbed about not being able to get the information and contacted the local advocate to reaffirm her rights. As a result of her concerns and discussions with the advocate, Mrs D decided to seek a second opinion from a specialist, and contacted her GP's nurse to organise a referral letter. Within the hour her doctor had telephoned her, having recognised her distress, and asked to meet with her later the same day. Mrs D's advocate offered to support her, but Mrs D felt able to proceed alone. She reported back to the advocate that the meeting had gone well and she had received the information she required. The doctor apologised for the distress caused and assured her that he would support her in obtaining a second opinion.

Mediation

The Commissioner may call a mediation conference at any stage. Mediation is often a very effective way of resolving complaints, and provides an opportunity for the parties to agree to a fair outcome with minimum delay and cost.

The parties meet across the table, with or without support persons, to discuss their concerns. Although the parties may have a lawyer present, this is not necessary. An impartial mediator assists the parties to define the issues in dispute, explore options for resolution of the complaint, and find their own solutions to the dispute. All statements made during mediation are confidential, and if a deed of settlement is signed it is a full and final settlement of the issue.

If a complaint is not resolved by mediation, the Commissioner will decide what (if any) further action to take.

Case study

Mr E was admitted to a hospital Emergency Department after injuring himself in a car accident that morning. On assessment, his main complaint was abdominal and back pain. Xrays of his back and neck showed no fractures, and he was discharged around 5pm. Mr E's condition deteriorated and he was readmitted to the Emergency Department at 10pm with pain in the kidney region and symptoms of shock. He was reassessed and discharged home with pain relief and treatment for a urinary tract infection. Four days later he deteriorated markedly, with disorientation, increased abdominal and back pain, and weakening of his legs. He was admitted to Intensive Care and received treatment for a contusion of the small bowel. Mr E continued to complain of intermittent back pain, but another Xray showed no fracture. However, a further Xray and CT imaging taken a few days later indicated a fractured spine. Mr E experienced increasing heaviness in his legs and subsequently developed paraplegia.

This serious complaint concerned the standard of care Mr E received at the hospital. The primary issue was the failure of hospital medical staff to diagnose the fracture, which left Mr E paralysed. The complaint also concerned pain management, nursing care, and communication.

The Commissioner commenced an investigation and, after reviewing the hospital's response, referred the matter for expert orthopaedic advice. The advisor considered that, overall, the care Mr E received was satisfactory. Mr E's fracture was not displaced at the time of initial Xray investigation and was therefore hidden from view. The advisor stated that this was an exceptionally complex case, and that Mr E had received good management and well documented, compassionate care.

In light of the expert clinical advice, and the unresolved communication concerns, the matter was considered appropriate for mediation. As Mr E's family was Māori, the Commissioner engaged a Māori mediator with knowledge of cultural issues. The family and the District Health Board were provided with a copy of the expert advice prior to the mediation conference, to guide them in their discussions.

The mediation conference resulted in a successful outcome. This included a written apology by the Board to Mr E and his whānau, as well as the instigation of a process to restore his mana. In its letter of apology, the Board commented that the mediation was a learning experience for all involved, and that the knowledge would be applied for the benefit of all patients.

Investigations

Some complaints, such as those involving allegations of serious professional misconduct, sexual impropriety, complex systems issues, or public safety issues, are not appropriate for low level resolution and proceed to a formal investigation. The Commissioner may commence an investigation in response to a complaint or on the Commissioner's own initiative.

The investigation process is independent and impartial. Providers are informed of the investigation, given a copy of the letter of complaint, and asked to respond to the complaint within 15 working days. The provider's response is very important as it helps the Commissioner to decide whether to refer the matter to advocacy or mediation, and enables the Commissioner to form an opinion whether there has been a breach of the Code.

Registration authorities, such as the Medical Council of New Zealand, are notified of any investigation.

Where the appropriate standard of care is in issue, expert independent clinical advice is obtained to assist the Commissioner to form an opinion. Relevant professional groups, such as the Royal New Zealand College of General Practitioners, nominate expert advisers, and the advisers are named in the Commissioner's report.

The HDC Act gives the Commissioner wide powers to gather relevant information. This includes the ability to summon witnesses, to take evidence under oath, and to require the production of relevant documents. It is an offence to obstruct or hinder the Commissioner or any other person in the exercise of their powers under the HDC Act, or to give false or misleading information.

Most investigations end in a written report from the Commissioner to the parties. Before forming a final opinion, the Commissioner sends a provisional report to the provider (if it contains adverse comment about the provider), or to the complainant (if there is a provisional finding of no breach of the Code). The Commissioner considers responses to the provisional report, and sometimes seeks further expert advice, before issuing a final report. These reports are usually published in an anonymised form on the HDC website.

A simple investigation usually takes six to twelve months; a complex investigation may take twelve to eighteen months.

Relationships with other organisations

Complaints may be referred to other agencies or persons involved in the health and disability sector. For example, a complaint of a breach of patient confidentiality will be referred to the Privacy Commissioner, and a complaint of discrimination will usually be referred to the Human Rights Commission.

Working with other agencies is an important part of promoting and protecting the rights of consumers. The Commissioner is required to cooperate and share information with a number of other agencies and persons, so that relevant information can be analysed and acted upon to identify public safety concerns, and so that duplication can be minimised.

The Commissioner has wide discretion to refer a matter to an appropriate person or authority. For example, the Commissioner may contact ACC if it appears that the consumer may be entitled to compensation, and concerns about inappropriate prescribing may be referred to Medsafe.

The Commissioner also has a duty to report any public safety issues to the appropriate body or person.

Options where there is a breach of the Code

Where an investigation reveals a breach of the Code, the Commissioner has a number of options. Usually, the Commissioner's final report makes some recommendations. For example, the Commissioner may recommend that the provider offer the consumer a written apology, review his or her practice in the light of the Commissioner's report, undertake further education, or implement appropriate systems to prevent a recurrence. The Commissioner cannot order

compensation, but occasionally may recommend that a provider refund money paid for substandard services.

The Commissioner's opinion is reported to the relevant registration authority and, in the case of a doctor, the Medical Council may be asked to consider the need for a performance assessment. Copies of the report may also be sent to the Minister of Health, funders, or any other appropriate agency.

Reports with significant educational value are distributed to the appropriate colleges and posted on the Commissioner's website (www.hdc.org.nz) in an anonymised form. The Commissioner is empowered to name individual providers publicly, and will do so in exceptional circumstances (eg, where the provider poses a risk of harm to the public).

The Commissioner uses individual complaints to promote wider systemic improvements. In the cases below, the Commissioner investigated complaints involving deficiencies in the co-ordination of care (including handover) and supervision.

Case study

A man complained about the care his 55-year-old wife, Mrs A, received following surgery for breast cancer in a public hospital. It had been agreed between Mrs A, who had significant comorbidities, and her surgeon prior to surgery that the operation would take place in the local public hospital rather than a private hospital, because she required a high dependency unit (HDU) bed. However, following the operation, it was found that no HDU bed had been booked, and HDU staff were unaware of the intention to transfer Mrs A to HDU postoperatively.

As no HDU bed was available, and a bed was not available in the appropriate surgical ward, the anaesthetist arranged to transfer Mrs A from theatre to a busy orthopaedic ward. The anaesthetist failed to inform the surgeon (who was shocked to find out after Mrs A's death that this had occurred). Mrs A was also nursed in a standard-sized hospital bed, which was unsuitable given her size. A larger bed had not been arranged as a result of poor communication.

The only guidance given to nursing staff was to perform half-hourly clinical observations until Mrs A was "stable". The anaesthetist said he gave "clear instructions" to nurses for Mrs A's care on the ward ("the need for pulse oximetry monitoring, supplemental oxygen and regular observations"), but did not document the instructions.

Mrs A's postoperative care was jeopardised because monitoring equipment was unsuitable or was not functioning, and the ward was inadequately staffed to provide Mrs A with appropriate care, given her special needs. Mrs A died the evening after surgery.

The Commissioner found that Mrs A did not receive postoperative care of an appropriate standard, and clinical staff did not properly co-ordinate their care. The numerous failings in the care provided to Mrs A were caused by poor planning of a scheduled operation for a patient with significant risk factors. The Commissioner found that the District Health Board breached Rights 4(1), 4(2) and 4(5) of the Code.³ In light of these events, the Board extensively reviewed and made changes to various hospital systems and staff guidelines.

This case highlights the importance of the co-operation of a large team of clinical and non-clinical staff in the management of a patient in hospital. The team is responsible for ensuring that the care provided to a patient is of an appropriate standard, from first assessment until discharge from hospital. A hospital must have adequate systems in place to ensure that a patient's care is assessed, planned and delivered appropriately.

Case study

The Commissioner was alerted to concern about failed tubal ligation procedures undertaken by Dr Roman Hasil in 2005-06. The Commissioner initiated an inquiry into the standard of care provided by Dr Hasil at Wanganui Hospital, and the steps taken by Whanganui DHB to ensure that Dr Hasil was competent to practise.

One aspect of the inquiry involved determining whether Dr A's supervision of Dr Hasil was adequate. Dr A was responsible for Dr Hasil's regulatory and clinical supervision when he was the Clinical Director and Head of Department.

A supervisor has a duty to provide supervision with reasonable care and skill and in accordance with professional standards. This duty is recognised at common law.⁴ Regulatory supervision is supervision provided at the request of the Medical Council for doctors who are provisionally registered, such as international medical graduates newly registered in New Zealand. The Medical Council may require that the supervisor assess and report on the performance of the supervised doctor.⁵

Clinical supervision is the more familiar type of supervision in medicine where a more senior doctor supervises a more junior doctor within a clinical team (eg, a senior doctor of a registrar or medical officer; a registrar of a house surgeon).⁶ A basic principle of clinical supervision is that the supervisor may delegate care to the supervisee where he or she has good reason to believe that they are competent to carry out the delegated tasks. A critical issue in cases involving clinical supervision is whether the supervisor acted reasonably in relying on the supervisee acting in the role assigned. In deciding this issue, several factors are considered, including the supervisee's experience and the supervisor's knowledge of their skills and experience.

Dr Hasil's CV indicated that he had more than 20 years' experience in obstetrics and gynaecology and he had been working in a comparable health system for a number of years. Dr Hasil was employed as a medical officer, under Dr A's supervision, to assist the specialists. At the outset, Dr A took appropriate steps to familiarise himself with Dr Hasil's practice. Dr A directly observed Dr Hasil for a few weeks and considered that he was competent to provide obstetric and gynaecology services independently. Dr A met with Dr Hasil on an "ad hoc" basis to discuss his clinical practice, frequently at first, then less over time. This contact was largely limited to informal discussions rather than formal meetings or routine peer review.

It was only when Dr A took over the review of a number of Dr Hasil's patients (during his leave) 14 months later that he realised the extent of Dr Hasil's deficiencies. Dr A had significant concerns about the safety of Dr Hasil's practice, which he reported to the DHB.

Dr A conceded that with hindsight his supervision was not adequate and failed to promptly identify the extent of Dr Hasil's shortcomings. Dr A should have increased the frequency and regularity of his meetings with Dr Hasil, and routinely reviewed cases with him to be satisfied that he was practising safely. If this was not feasible, he should have alerted management and the Medical Council that he could not fulfill his supervisory responsibilities.

The Commissioner concluded that Dr A, was aware of concerns about Dr Hasil, but did not consider that he was unsafe. Dr A followed up concerns with Dr Hasil and remained satisfied that he was performing to an acceptable standard. In hindsight, that was an error of judgement, but given what he knew at the time, Dr A took reasonable actions to supervise Dr Hasil.⁷

This case demonstrates that effective clinical supervision is critical for safe health care. A system based on delegation without supervision and responsibility will not work to the benefit of the patients and the community.

Proceedings

Following a finding of a breach of the Code, the Commissioner may refer a matter to the independent Director of Proceedings, to decide whether legal proceedings will be issued against the providers concerned. Before referring a matter, the Commissioner must give the provider an opportunity to comment on the proposed referral. The Commissioner must also have regard to the wishes of the consumer and complainant and the public interest (including any public health or safety issues).

The Director of Proceedings may take proceedings before the Human Rights Review Tribunal and/or the Health Practitioners Disciplinary Tribunal, or may decide to take no further action. An aggrieved person may bring proceedings before the Human Rights Review Tribunal where the Commissioner, having found a breach of the Code, decides not to refer the matter to the Director of Proceedings, or where the Director of Proceedings decides not to take proceedings.

The functions of the Health Practitioners Disciplinary Tribunal are outlined in chapter 24.

The Human Rights Review Tribunal

Where proceedings are brought before the Human Rights Review Tribunal, the Tribunal has the power to award a number of remedies, including

- a declaration that the provider's action is in breach of the Code
- an order restraining the provider from continuing or repeating the breach
- an order that the provider perform any specified acts with a view to redressing any loss or damage suffered by the consumer as a result of the breach
- damages of up to \$200,000 (including damages awarded in respect of loss suffered, expenses reasonably incurred, humiliation, loss of dignity, injury to the feelings of the consumer, and any action that was in flagrant disregard of the consumer's rights), and
- any other relief the Tribunal thinks fit.

However, an important limitation is that where a person has suffered personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, no damages other than punitive damages (where the provider's action was in flagrant disregard of the consumer's rights) may be awarded. While the Tribunal has found two doctors to have breached the Code, no award of damages has been made.

Conclusion

The Commissioner promotes resolution of individual complaints and systemic improvements in health care. The Commissioner's focus is on resolution, not retribution; learning, not lynching.

How HDC handles complaints about doctors

459 complaints

54 investigations

27 breach findings

2 disciplinary
hearings

2007/2008



References

1. For fuller analysis, see “The Code of Patients’ Rights”, chapter 2 in Skegg and Paterson (eds.), *Medical Law in New Zealand* (2006).
2. For fuller analysis, see “Assessment and Investigation of Complaints”, chapter 22 in Skegg and Paterson (eds.), *Medical Law in New Zealand* (2006).
3. See *Opinion 06HDC19538* (Health and Disability Commissioner, 12 March 2008), www.hdc.org.nz.
4. *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC), paras 24–25.
5. Health Practitioners Competence Assurance Act 2003, section 23.
6. R Paterson and M van Wyk, “Supervisory Responsibility of Specialists” (2002) 10 *Journal of Law and Medicine* 187, 190.
7. See *Whanganui Inquiry Report* (Health and Disability Commissioner, February 2008), <http://www.hdc.org.nz/publications/other-reports>.